

contribution limits so that parties can match a wealthy candidate's personal spending that goes beyond an individual contribution limit. No longer will the millionaire have a nearly insurmountable advantage.

This bill increases individual contribution limits to \$2000 for a candidate for federal office. It does not increase PAC contribution limits. It bans soft money for federal parties and also for state parties in those cases where they are joint federal and state elections.

Certain reforms I support are not here; I favor a requirement that candidates must raise half of their campaign funds in their own state. I support lowering PAC contribution limits to match the amount an individual can give. But the fact these items are missing does not mean I can't support the good things that are here.

Mr. Speaker, this is a good package of bills which makes some much needed reforms. I am pleased to support each of them.

MANAGED CARE AND MENTAL  
HEALTH: WHY THE PATIENTS'  
BILL OF RIGHTS IS IMPORTANT

**HON. FORTNEY PETE STARK**

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, March 31, 1998*

Mr. STARK. Mr. Speaker, I am proud to join today with my colleagues to urge support for passing the Patients' Bill of Rights Act of 1998, a bill that would give millions of Americans enrolled in managed care plans a measure of control over the quality of care they receive.

For consumers of mental health and substance abuse benefits—which are often arbitrarily capped at a particular dollar level—this bill contains key quality provisions. It provides for continuity of care, access to specialists, choice of specialist, enables exceptions from overly restrictive drug formularies, and provides for an independent external appeals process.

The bill will guarantee that consumers can continue seeing their providers for 90 days after they change plans if they are in the middle of a course of treatment. For those with psychiatric disabilities, this continuity of care provision is critically important, since studies show that a sudden change of doctors for patients with serious psychiatric disorders can result in devastating setbacks.

The abrupt termination of psychiatric services to thousands of Los Angeles County Medi-Cal beneficiaries last year illustrates this point well.

Last year, the California State Department of Health contracted with Foundation Health to provide comprehensive medical services to its Medi-Cal population in Los Angeles. In turn, Foundation subcontracted out the provision of psychiatric services to MCC Behavioral Health Care. When MCC's contract ended, it notified 5,000 enrollees that their mental health services would be terminated in two weeks.

All were undergoing a course of psychiatric treatment, and many suffered from severe psychiatric disorders, such as schizophrenia, bipolar disorder, or major depression. Most were not fully fluent in English. A full-blown crisis was averted when the Los Angeles County Department of Mental Health offered

to care for the notified patients—but the Department was not fully equipped to do the job. As a result, some of the most severely disabled fell through the cracks and were lost to treatment.

Beyond continuity of care, the Patients' Bill of Rights would boost consumer confidence in HMOs with a simple requirement that health plans provide a list of contracted providers and their qualifications on request and that enrollees be able to choose among the providers who serve the plan members. This requirement would apply to mental health providers if the plan offers mental health and substance abuse services.

Today, consumers in managed care plans are not commonly given a list of the mental health providers in their own plans. When enrollees call to seek psychiatric care, they are often required to reveal confidential information about themselves over the phone to a "triage" staffer whom they don't know—and who may have no formal mental health training. The staffer then generally gives the caller names of one or two mental health professionals who are selected on the basis of zip code—not based on an assessment of the individual's need for a particular type of care.

In an article published on May 6, 1997, The Washington Post questions whether zip code referrals produce good patient care results. The article discusses the experience of Mark Hudson, who worked for a Blue Cross/Blue Shield plan as a telephone referral assistant in Massachusetts from 1992 to 1995. "I did the diagnosis and approval" for 80–100 calls a day for plan subscribers, Hudson is quoted as saying. He routinely made referrals to two therapists located in the town where the callers lived, regardless of the medical needs they described. Hudson has no mental health training, and says Blue Cross officials specifically instructed him not to provide enrollees with the names of other approved therapists.

Mr. Speaker, this makes no sense at all. Consumers who need mental health services should have the same freedom to select from a full panel of providers just as those seeking physical care typically can. The Patient Bill of Rights would help equalize this unfair practice.

Access to appropriate prescription drugs for psychiatric disorders is another paramount issue. In a 1997 survey, the National Alliance for the Mentally Ill found that five of the nation's largest behavioral health care companies failed to provide access to breakthrough antipsychotic medications. Yet for serious disorders such as schizophrenia, older medications may give only partial relief, and have far more serious side effects.

There is a requirement in many managed care plans that psychiatrists must first document two failures of older medications before a new one can be approved. Such policies are penny wise and pound foolish, since patients suffering severe side effects from these sometimes-outdated drugs can easily wind up needing hospitalization. Obviously, this can also result in suboptimal psychiatric care.

By requiring an exception process to the drug formularies often used by plans and by allowing access to the external appeals process, the bill will allow mental health patients to have stronger protection than they do today. The external appeals process required by this bill offers an additional important level of protection for consumers of mental health and substance abuse services. Without it, consum-

ers are forced to receive final medical decisions from health plans that hold a financial interest in denying care.

In an article published on March 3, 1998, U.S. News explores this risk in some details. The article discusses the experience of Dr. Linda Peeno, who worked as an HMO's medical director—the person who must ultimately approve or reject requests for care. "The decision [to approve a voice machine for a plan beneficiary—a young woman who suffered a usually-fatal brain stem stroke] is now mine, and I feel the pressure to find a way to say no", Dr. Peeno is quoted as saying. She went on to add, "If I cannot pronounce it medically unnecessary, then I have to find a different way to interpret our medical guidelines or the contract language in order to deny the request." Unhappy with her role as a medical care denier, Dr. Peeno left the industry in 1991.

Mr. Speaker, mental health and substance abuse is probably the area where managed care has the most serious problems. We need an entire bill devoted to addressing these special problems—but the bill I am cosponsoring today is a good beginning on these problems. In the coming weeks, I will be introducing separate legislation to deal with the unaddressed mental health and substance abuse consumer issues. In the meantime, we should not delay in passing the important protections contained in the Dingell-Gephardt-Kennedy bill.

HONORING OUR DESERVING  
VETERANS

**HON. RON PACKARD**

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, March 31, 1998*

Mr. PACKARD. Mr. Speaker, I rise today to identify an inequity that has gone unresolved for too long. This inequity currently exists in the process of honoring our veterans in the Navy and Marine Corps who served our nation from 1943 to 1961. These proud men and women deserve to be recognized in the same fashion as their counterparts in the other service branches.

The Navy Combat Action Ribbon is awarded to Navy and Marine Corps personnel based upon active participation in ground or surface combat beginning March 1, 1961. The equivalent Army award, the Combat Infantry Badge, has been given to Army personnel since July 4, 1943. Why should this unfair discrepancy stand?

H.R. 543, a bill introduced by Rep. MICHAEL McNULTY, would erase the imbalance between the eligibility date requirements of the Navy Combat Action Ribbon and its counterparts in the other service branches. H.R. 543 provides for an award of the Navy Combat Action Ribbon to Navy and Marine Corps personnel during the period between July 4, 1943, and March 1, 1961.

Mr. Speaker, I believe we must pass H.R. 543 to correct the inequality in how we honor our veterans. As the current award process stands a large segment of the veterans' population is being excluded from proper recognition for the dedication and sacrifice they proudly made for our country. By passing H.R. 543 we would rightfully honor those who bravely served our nation.